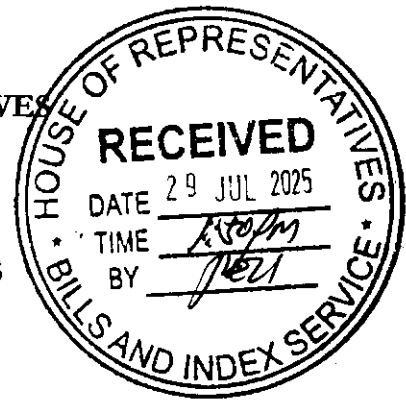




Republic of the Philippines
HOUSE OF REPRESENTATIVES
Quezon City, Metro Manila

TWENTIETH CONGRESS
First Regular Session

House Bill No. **2467**



Introduced by **Representative GIRLIE E. VELOSO**

EXPLANATORY NOTE

The 1987 Constitution affirms the duty of the State to protect and promote the right to health and mandates that health development be pursued through an integrated and comprehensive approach, with priority given to the underprivileged, sick, elderly, disabled, women, and children. Republic Act No. 11223 or the Universal Health Care (UHC) Act reinforces this mandate by ensuring health system equity, quality, and resilience through institutional reforms and service integration. However, existing frameworks remain incomplete in addressing the continuum of care for patients requiring extended support beyond acute or primary treatment, especially during periods of institutional stress. While laws exist for emergency response and hospital licensing, there remains a legislative gap in systematizing patient decompression, long-term recovery, and the integration of halfway support as part of routine healthcare service delivery and facility resilience.

Hospitals across the country, both public and private, operate under near-constant capacity strain. Overcrowding, hallway admissions, and premature discharges are no longer exceptional; they are everyday conditions driven by structural shortages, social determinants of health, and unequal access to post-acute care. The notion of “surge” must be redefined not solely as disaster-induced, but as a chronic reality that compromises quality, continuity, and dignity in care. Existing halfway houses, initially designed for temporary shelter or geographic access, are underutilized as part of a broader system of patient decompression and reintegration. Moreover, without institutional mandates and shared operational protocols, referral systems remain fragmented, recovery pathways are inconsistent, and the burden is unequally distributed across facilities. The absence of resilient infrastructure and structured transitions from hospital care to community or supportive recovery settings continues to undermine both health outcomes and institutional efficiency.

This bill seeks to institutionalize Integrated Recovery Support Facilities (IRSFs) as essential components of the national health infrastructure not merely as emergency surge responses, but as

enduring mechanisms for decompression, recovery, and reintegration that address the persistent pressures faced by hospitals nationwide. Rather than establishing parallel systems, the bill strengthens existing referral mechanisms by embedding continuity-of-care protocols, structured recovery pathways, and reintegration frameworks that are patient-centered and adaptable to institutional capacities. IRSFs are designed to integrate with and enhance current hospital infrastructure by utilizing, upgrading, or linking existing wards, shelters, halfway houses, or community facilities where feasible, and constructing new modular units only when necessary. While IRSFs are established specifically within government hospitals and health centers, the bill also mandates system-wide support services such as referral interoperability, continuity of care protocols, business continuity plans, and recovery-focused care that span public and private providers. Through this adaptive, integrative approach, the bill transforms decompression and continuity of care from ad hoc practices into standard, resilient features of the health system.

The enactment of this measure will alleviate chronic congestion in hospitals, allow clinical institutions to focus on their core competencies, and give patients a dignified, structured path toward full recovery and reintegration. IRSFs will serve as flexible, scalable care nodes, capable of bridging gaps in rehabilitation, psychosocial support, post-treatment step down, and sustained care, particularly for vulnerable or displaced individuals. By embedding IRSFs in both emergency and non-emergency service delivery, the bill promotes a health system that is adaptive, equitable, and able to function even under prolonged strain. It aligns national infrastructure policy with evolving patient needs and the operational realities of both government and private hospitals, while strengthening anticipatory planning, surge absorption, and care continuity as core public health functions.

Through this legislative measure, the State redefines resilience as sustained adaptability in the face of institutional demand, structural inequities, persistent health burdens, and varied realities on the ground. It bridges hospital-based care and social reintegration as a continuum, and provides a forward-looking institutional response to the country's overburdened health facilities. Most importantly, it affirms the primacy of the patient experience in system design.

In view of the foregoing, support for the enactment of this measure is earnestly sought.


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TWENTIETH CONGRESS
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House Bill No. **2467**

Introduced by **Representative GIRLIE E. VELOSO**

**AN ACT ESTABLISHING A NATIONAL HEALTH RESILIENCE AND
CONTINUITY OF CARE SYSTEM THROUGH THE INSTITUTIONALIZATION OF
INTEGRATED RECOVERY SUPPORT FACILITIES IN GOVERNMENT
HOSPITALS, STRENGTHENING EMERGENCY PREPAREDNESS AND PATIENT
SUPPORT, AND PROVIDING FUNDS THEREFOR**

Be it enacted by the Senate and House of Representatives of the Philippines in Congress assembled:

1 **SECTION 1. Short Title.** — This Act shall be known as the “Health Resilience and
2 Continuity of Care Act”.

3 **SECTION 2. Declaration of Policy.** — It is the declared policy of the State to protect and
4 promote the right to health of every Filipino and to institutionalize a health system that is universally
5 accessible, resilient, equitable, and responsive to emergencies, transitions in care, and the
6 socioeconomic realities of patients.

7 Toward this end, the State shall establish a national health resilience and continuity of care
8 framework that enables government hospitals to anticipate, absorb, and adapt to public health
9 emergencies; to ensure uninterrupted, coordinated medical care across all levels of treatment; and to
10 support patients and their families through recovery and reintegration.

11 The State further recognizes the urgent need to construct or designate integrated, multi-use
12 facilities in government hospitals that function as:

13 (a) Surge shelters during pandemics, disasters, or extraordinary increases in patient volume;

- (b) Transition wards for patients requiring temporary clinical support following hospitalization; and
- (c) Halfway houses for indigent, geographically displaced, or socioeconomically disadvantaged patients and their companions.

In pursuit of these goals, the State shall adopt a whole-of-government and whole-of-society approach, institutionalizing inter-agency coordination, decentralized implementation, and locally responsive models of care, consistent with the principles of universal health care, social justice, and disaster risk reduction.

SECTION 3. Definition of Terms. — As used in this Act:

- (a) Health Resilience refers to the capacity of the health system, including its institutions, personnel, infrastructure, and processes, to anticipate, absorb, adapt to, and recover from health emergencies, disasters, or other disruptions while continuing to deliver essential services.
- (b) Continuity of Care refers to the coordinated and uninterrupted provision of health services across different stages and levels of patient need, including pre-hospital, inpatient, transitional, outpatient, and post-discharge support, particularly for vulnerable or displaced populations.
- (c) Surge Shelter refers to a temporary or permanent facility within or adjacent to a government hospital designed to accommodate patients during periods of extraordinary demand, such as pandemics, mass casualty events, or natural disasters. Surge shelters may function as overflow treatment areas, triage zones, or isolation units.
- (d) Transition Ward refers to a step-down facility for patients who no longer require critical or full hospital admission but are not yet fit for discharge due to pending diagnostic, therapeutic, or logistical needs. Transition wards facilitate clinical recovery, improve bed turnover, and reduce premature discharges.
- (e) Halfway House refers to a non-clinical, temporary lodging facility located within or near a government hospital, intended to provide short-term shelter for patients and/or their families who are awaiting treatment, undergoing outpatient care, or recovering post-discharge, especially those who are indigent or from geographically distant areas.
- (f) Ancillary and Support Services refers to essential non-clinical services that may be provided in the above facilities, including psychosocial support, basic meals or nutrition, patient navigation, referral coordination, transportation assistance, and health literacy or education.
- (g) Government Hospitals refers to all public hospitals owned, managed, or operated by the Department of Health (DOH), local government units (LGUs), or any other instrumentality of the government.

- (h) Vulnerable Populations refers to persons or groups who are at greater risk of inadequate access to health services due to factors such as poverty, displacement, geographic isolation, chronic illness, disability, advanced age, pregnancy, or lack of social support.
- (i) Emergency Health Event refers to any occurrence, whether natural or man-made, that results in a significant increase in patient volume, hospital utilization, or public health risk, including but not limited to pandemics, epidemics, typhoons, earthquakes, fires, or armed conflict.
- (j) Integrated Recovery Support Facility (IRSF) refers to a designated physical infrastructure within a government hospital that serves as a modular system for long-term recovery, hospital decongestion, and continuity of care. It may consist of one or more components, such as a surge shelter, transition ward, halfway house, or ancillary services, operating under unified management and integrated operational protocols. The configuration of an IRSF shall be adaptable to the hospital's needs, capacity, and surge vulnerability.
- (k) Displaced Population refers to individuals or families who have been forced to flee or evacuate their habitual residence due to natural disasters, armed conflict, public health emergencies, or other situations of serious disturbance, resulting in the temporary or prolonged disruption of their access to essential services including healthcare.
- (l) Geographically Distant refers to patients or individuals residing at least two (2) hours away from the nearest referral hospital by usual means of transportation, or in areas officially designated by the Department of Health as Geographically Isolated and Disadvantaged Areas (GIDAs).
- (m) Companion/Caregiver refers to a family member or legally authorized person who provides necessary physical, emotional, or logistical support to a patient during hospitalization or transitional care, especially when required due to the patient's age, disability, chronic condition, or vulnerability.
- (n) Emergency Preparedness refers to the state of readiness of a health facility or hospital to manage and respond to sudden increases in patient volume or adverse public health events, aligned with the Hospital Emergency Preparedness and Response Plan (HEPRP) of the Department of Health and applicable national disaster frameworks.
- (o) Patient Recovery refers to the intermediate phase following acute medical intervention during which the patient no longer requires intensive or specialized hospital care but continues to need medical supervision, rehabilitative services, or temporary shelter.

SECTION 4. Scope and Coverage. — This Act shall apply to all government hospitals and health facilities operated by the DOH, LGUs, and other national government agencies, for purposes of establishing and operationalizing Integrated Recovery Support Facilities (IRSFs) as designated physical infrastructure for long-term recovery and hospital decongestion.

The provisions on referral protocols, continuity of care, and resilient facility operations under this Act shall likewise apply to both public and private health facilities participating in the national health system, subject to guidelines to be issued by the DOH.

1 **SECTION 5. Establishment of the Integrated Recovery Support Facility (IRSF). —**

2 To fulfill the objectives of long-term recovery, hospital decongestion, and continuity of care, there is
3 hereby established an Integrated Recovery Support Facility (IRSF) as a modular, hospital-based
4 infrastructure system. Its modular nature allows for adaptability, cost-efficiency, and rapid
5 deployment in response to evolving health needs and emergencies. The IRSF shall support the
6 establishment or enhancement of the following hospital-based facilities and accompanying services:

- 7 (a) Multi-Use Surge Shelters;
- 8 (b) Transition Wards;
- 9 (c) Halfway Houses; and
- 10 (d) Ancillary and Support Services Infrastructure.

11 The configuration, presence, or activation of each component shall be determined by
12 institutional readiness, patient volume, local health needs, and vulnerability to surge events. The
13 IRSF need not comprise all components at once and may be scaled or activated based on situational
14 requirements.

15 The DOH, in coordination with relevant agencies, shall issue guidelines for the phased
16 establishment, infrastructure development, and operationalization of IRSFs in qualified government
17 hospitals.

18 **SECTION 6. Functions and Objectives of the IRSF. —** The IRSF shall serve as a

19 modular and adaptive infrastructure system within qualified government hospitals to ensure
20 continuity of care, decongest critical wards, and support patients and families in post-crisis recovery.
21 Specifically, the IRSF shall fulfill the following functions:

- 22 (a) Provide surge response capacity by serving as a flexible and immediately deployable
23 shelter or holding space during medical, humanitarian, or public health surges;
- 24 (b) Support transitional and step-down care by accommodating patients who no longer
25 require intensive hospital services but need continued observation, rehabilitation, or
26 social reintegration support;
- 27 (c) Facilitate family and patient recovery by providing halfway housing and other supportive
28 services for patients and families undergoing long-term recovery from major illness,
29 trauma, displacement, or disaster-related events;
- 30 (d) Ensure integrated service delivery by promoting unified case management through the
31 physical co-location of medical, psychosocial, and logistical services under a single
32 operational framework;
- 33 (e) Strengthen hospital resilience and continuity by reducing pressure on emergency and
34 inpatient units while maintaining hospital functionality during periods of sustained
35 demand;

- (f) Serve as a convergence point for inter-agency services by enabling the coordinated delivery of services from the Department of Health (DOH), Department of Social Welfare and Development (DSWD), LGUs, and other relevant agencies during recovery phases.

SECTION 7. Guidelines and Standards for IRSF Implementation. — To ensure the effective establishment, integration, and functioning of Integrated Recovery Support Facilities (IRSFs), the DOH, in coordination with the Department of Public Works and Highways (DPWH) and other relevant agencies, shall adopt and issue comprehensive physical, operational, and institutional standards governing the design, construction, management, and sustainability of the IRSF components outlined in Section 5. These guidelines shall include, but not be limited to, the following:

- (a) **Eligibility and Site Criteria.** Parameters for identifying qualified government hospitals and localities based on surge vulnerability, hospital congestion, population density, geographic risk exposure, and historical incident data.
- (b) **Design and Infrastructure Standards.** Modular, climate-resilient, and space-efficient architectural standards tailored to the distinct functions of Multi-Use Surge Shelters, Transition Wards, Halfway Houses, and Ancillary Support Facilities.
- (c) **Phased Implementation.** The IRSF program shall adopt a phased implementation strategy that acknowledges both the enhancement of existing hospital-based systems and the establishment of new integrated facilities where none currently exist. Development of core components shall proceed in alignment with institutional readiness, community vulnerability assessments, and available resources. Implementation shall prioritize tertiary hospitals, regional medical centers, and national specialty hospitals with high patient volume, complex service demand, or surge risk. In succeeding phases, the program shall expand to include provincial, district, and other qualified government hospitals, in alignment with the country's national health infrastructure and service delivery development plans.
- (d) **Scaling and Activation.** Scaling of IRSF components shall be based on localized needs assessments, allowing facilities to expand or downscale psychosocial, surge, discharge, half-way house, and reintegration services in proportion to the severity or frequency of high-impact events. Activation shall occur in response to declared emergencies, mass casualty incidents, or other service escalation triggers, and shall be informed by real-time assessments of both community needs and institutional response capacity. Activation protocols shall be defined by the DOH in coordination with relevant national and local agencies.
- (e) **Operational Protocols.** Uniform standards and protocols for patient intake, case management, referral systems, staffing, and coordination with local health units and disaster response agencies.
- (f) **Maintenance and Sustainability.** Mechanisms for infrastructure maintenance, continuous training and capacity building, and integration into hospital budgets and local health development plans.

(g) Monitoring and Evaluation. Clear indicators, tools, and feedback systems to regularly assess the functionality, responsiveness, and public benefit of IRSFs, including participatory inputs from patients, staff, and local stakeholders.

The DOH shall ensure that the guidelines are inclusive, responsive to local contexts, and periodically updated to reflect new data, technologies, and lessons from health and disaster response operations.

To ensure sustained infrastructure investment and institutional support, the IRSF program shall be integrated into the Department of Health's Health Facilities Enhancement Program (HFEP) or its succeeding equivalent. This integration shall facilitate long-term planning, phased capital outlays, and convergence with national and local health infrastructure priorities. The inclusion of IRSF components in HFEP shall be guided by the eligibility criteria, design standards, and implementation strategies set forth in this Act.

SECTION 8. Referral System Modernization. — To ensure continuity of care and prevent avoidable deaths, especially during emergencies and life-threatening cases, all public hospitals and health facilities, including those hosting Integrated Recovery Support Facilities (IRSFs), shall upgrade and align their patient referral systems with the National Patient Navigation and Referral System (NPNRS), in accordance with DOH guidelines.

Shifting towards patient-centeredness, the referral system shall:

- (a) Treat life-threatening, critical care, and time-sensitive conditions, including, but not limited to cardiac arrest, stroke, severe trauma, obstetric and neonatal emergencies, infectious disease outbreaks (e.g., sepsis, dengue shock), and mental health crises, as non-deferrable and not subject to prior referral approval. Facilities shall render immediate care when feasible, or escalate patient transfers without delay;
- (b) Implement clear, mandatory protocols for obstetric, pediatric, and critical care handoffs, particularly in areas where lower-level facilities operate without proximate referral hospitals equipped for such cases;
- (c) Designate patient navigation focal persons to coordinate emergency referrals and escalation pathways;
- (d) Activate automatic escalation protocols when a referral is not acknowledged or fulfilled within prescribed timeframes, with real-time reporting to DOH-designated focal points;
- (e) Require all public health facilities to visibly and digitally display an up-to-date scope of services, availability of specialists, and service limitations, to inform patients, LGUs, and emergency services;
- (f) Enable interoperable real-time capacity mapping and digital dashboards across local and national referral networks; and
- (g) Activate surge protocols for handling peak caseloads and cascading referrals across neighboring facilities.

SECTION 9. Continuity of Care Protocols. — To complement and extend the existing NPNRS, the DOH, in coordination with the DSWD, Department of the Interior and Local Government (DILG), and concerned agencies, shall develop and implement Continuity of Care Protocols.

To ensure seamless patient recovery and prevent relapse or re-injury following emergency, clinical, critical, or disaster-related interventions, these protocols shall cover, but not be limited to:

- (a) Post-admission coordination across facilities and systems, including stepdown care, inter-facility transfers, and ward decongestion strategies;
- (b) Structured discharge planning that includes patient education, referrals to community-based services, and appropriate handoffs to LGU health and welfare personnel;
- (c) Reintegration support such as rehabilitation, mental health care, caregiving, and other long-term recovery services;
- (d) Real-time linkage with Malasakit Centers, health social work offices, and other designated patient assistance units to ensure that post-discharge needs are addressed without administrative delay.

These protocols shall operate in alignment with existing services and the eventual full integration of health social workers and welfare aides under a unified health-social care continuum.

SECTION 10. Resilient Facility Operations. — To strengthen the resilience of the country's health system in times of crisis, all public and private hospitals shall develop, maintain, and regularly update DOH-certified Business Continuity Plans (BCPs). These plans shall ensure uninterrupted delivery of critical services during emergencies and system disruptions.

At a minimum, the BCPs shall include the following components:

- (a) Surge Capacity Protocols, including temporary expansion of beds, workforce augmentation, and emergency resource allocation;
- (b) Telemedicine and Digital Triage Systems for remote assessment, consultation, and referral to appropriate care levels;
- (c) Referral Fallback Mechanisms, including designated alternate facilities and updated patient transfer agreements;
- (d) Supply Chain Contingency Plans, ensuring minimum stock levels, alternate sourcing, and logistics coordination for essential medicines, equipment, and PPEs.

The DOH shall issue standards, review compliance, and provide technical support for the certification and periodic audit of these plans.

1 Failure to maintain a certified BCP may be considered a breach of licensing or accreditation
2 requirements, subject to penalties under existing health facility regulations.

3 **SECTION 11. Roles and Responsibilities of Implementing Agencies.** — To ensure
4 the effective implementation, coordination, and sustainability of Integrated Recovery Support
5 Facilities (IRSFs) and their associated support services, the following roles are hereby assigned:

- 6 (a) The DOH shall serve as the lead implementing agency responsible for:
- 7 1. Issuing and updating national standards and guidelines for IRSF operations,
8 infrastructure, staffing, and referral systems;
 - 9 2. Overseeing the integration of support services into the broader public health and
10 recovery framework;
 - 11 3. Managing inter-facility and regional referral coordination under the NPNRS;
 - 12 4. Ensuring regulatory compliance, capacity development, and technical assistance to
13 LGUs and relevant agencies for both IRSFs and associated services.
- 14 (b) The DSWD shall coordinate the delivery of reintegration and social protection support
15 services in connection with IRSF operations, including but not limited to:
- 16 1. Psychosocial first aid and assessment;
 - 17 2. Assistance for displaced families and vulnerable individuals;
 - 18 3. Temporary shelter welfare casework and transition coordination; and
 - 19 4. Linkages to social amelioration, reintegration, and recovery programs.
- 20 The DSWD shall work closely with the DOH and LGUs to promote converged delivery
21 models that may include health social workers, community welfare aides, and
22 interdisciplinary recovery teams to ensure continuity of care beyond IRSF discharge.
- 23 (c) The DPWH shall provide technical support and oversight in the planning, construction,
24 retrofitting, and maintenance of IRSF infrastructure to ensure compliance with health
25 facility standards, climate resilience, and disaster risk reduction principles.
- 26 (d) Under the policy supervision and general oversight of the DILG, LGUs shall serve as the
27 primary on-ground co-implementers of this Act and shall be responsible for:
- 28 1. Operationalizing Integrated Recovery Support Facilities (IRSFs) within their
29 respective jurisdictions;
 - 30 2. Providing manpower, logistical, and administrative support in coordination with
31 relevant national agencies;
 - 32 3. Mobilizing local health, emergency, and social welfare personnel in support of IRSF-
33 related functions and services; and
 - 34 4. Ensuring real-time coordination with the DOH, the DSWD, the DILG, and other
35 concerned agencies during high-impact crises or service escalations.
- 36 (e) Other Agencies. Other national government agencies may be designated or engaged, as
37 necessary, to support specific mandates under this Act through joint administrative
38 issuances by the DOH, in consultation with implementing stakeholders.

39 **SECTION 12. Human Resource and Operational Support.** — To ensure the
40 responsive deployment of personnel during implementation, this Act shall establish flexible, needs-

1 based human resource mechanisms that support activation, scaling, and sustained operation of
2 Integrated Recovery Support Facilities (IRSFs) and support services.

- 3 (a) Conditional Hiring and Deployment. Government hospitals, LGUs, and relevant
4 implementing agencies shall be authorized to hire additional personnel, including health
5 workers, social workers, and allied professionals, on a job order or contract-of-service
6 basis as soon as any IRSF component is activated or determined to be needed, based on
7 operational readiness and local needs assessments.
- 8 (b) Designation and Reassignment of Personnel. Existing personnel may be designated or
9 reassigned to serve in IRSF-related functions. Staff may be given multiple or rotational
10 assignments across IRSF components or periods, depending on surge, scaling, or
11 seasonal needs. Such assignments shall include access to appropriate training and
12 continuing capacity development relevant to their designated functions.
- 13 (c) Creation of Permanent Positions. For IRSF components with sustained staffing needs,
14 DOH, DSWD, LGUs, and other implementing agencies may propose the creation of
15 permanent plantilla positions, subject to Civil Service Commission (CSC) and
16 Department of Budget and Management (DBM) regulations. Such positions shall be
17 identified in the Implementing Rules and Regulations (IRR).
- 18 (d) Interagency Coordination and Secondment. To maximize human resource efficiency and
19 institutional collaboration, the CSC, the DBM, the DOH, the DSWD, and the LGUs
20 shall establish protocols and standardized Memoranda of Agreement (MOA) templates
21 to govern the secondment, temporary transfer, or joint deployment of qualified
22 personnel from one agency or facility to another in support of IRSF operations.
- 23 (e) Emergency Health Reserve Corps. The DOH shall establish and maintain a national
24 database of trained reserve health workers, volunteers, retirees, and students qualified
25 under the DOH Disaster Risk Reduction and Management in Health (DRRM-H)
26 standards. These individuals may be mobilized during public health emergencies,
27 disasters, or other periods requiring surge capacity.
- 28 (f) Community-based Frontliners. Barangay Health Workers (BHWs) and community-based
29 volunteers shall be institutionalized as first-line resilience responders, particularly for
30 early detection, referral, and monitoring. Standardized referral and community-based
31 health protocols shall be integrated into their training and scope of duties.
- 32 (g) Training and Capacity Building. All personnel assigned, designated, or seconded to IRSF
33 functions shall undergo capacity-building programs, including but not limited to training
34 in trauma-informed care, discharge planning, halfway house operations, transitional care
35 skills, multi-agency coordination, and community-based reintegration. These programs
36 shall be regularly updated and aligned with the evolving needs and service delivery
37 models of the IRSF system. They shall be entitled to risk-based benefits consistent with
38 Republic Act No. 11712. Additional incentives may include deployment insurance,
39 hazard allowances, and certification credits for professional development and career
40 advancement.

SECTION 13. Monitoring, Evaluation, and Reporting. — To ensure accountability, effectiveness, and alignment with national health infrastructure goals, the following monitoring and evaluation mechanisms shall be institutionalized:

- (a) Integration with HFEP Monitoring. All infrastructure-related components of the IRSF shall be included in the HFEP monitoring framework of the DOH, in coordination with the DPWH. This includes target-setting, progress tracking, and reporting of physical and financial accomplishments.
- (b) Multi-Dimensional Evaluation Framework. The DOH, in coordination with the DSWD, LGUs, and relevant partners, shall develop and implement an evaluation framework covering both infrastructure and service delivery outcomes, including:
 - 1. Timeliness and adequacy of response,
 - 2. Quality of reintegration support,
 - 3. Human resource deployment effectiveness,
 - 4. Beneficiary satisfaction, and
 - 5. System responsiveness during crises.
- (c) Oversight and Reporting. An annual consolidated report shall be prepared by the DOH, and submitted to Congress and the President of the Philippines, detailing
 - 1. IRSF activations and service coverage,
 - 2. HR deployment and training accomplishments,
 - 3. Infrastructure development per HFEP,
 - 4. Budget utilization, and
 - 5. Systemic challenges and policy recommendations.
- (d) Community and Stakeholder Feedback. All health facilities with IRSF shall establish mechanisms for collecting community feedback, incident reports, and beneficiary assessments to support continuous improvement and transparency.

SECTION 14. Implementing Rules and Regulations. — Within ninety (90) days from the effectivity of this Act, the DOH, in coordination with the DSWD, the DPWH, the DILG, the National Disaster Risk Reduction and Management Council (NDRRMC), and other concerned agencies,, shall promulgate the Implementing Rules and Regulations (IRR) necessary to carry out the provisions of this Act.

The IRR shall include, at the minimum:

- (a) guidelines on facility standards, service delivery protocols, and activation triggers;
- (b) integration with existing health and disaster response systems;
- (c) funding allocation, maintenance, and sustainability mechanisms;
- (d) inclusion of IRSFs under the HFEP;
- (e) modernization of referral systems and continuity of care protocols in alignment with the National Health Referral System and related frameworks; and
- (f) monitoring, reporting, and accountability frameworks.

1 **SECTION 15. Appropriations.** — The amount necessary for the initial implementation of
2 this Act shall be charged against the current year's appropriations of the DOH and other
3 implementing agencies. Thereafter, the amount necessary for the continued implementation shall be
4 included in the annual General Appropriations Act (GAA).

5 Funds for the construction, retrofitting, and equipping of Integrated Recovery and Support
6 Facilities (IRSFs) shall be included under the HFEP of the DOH, in coordination with the DPWH,
7 subject to planning and prioritization standards.

8 **SECTION 16. Repealing Clause.** — All laws, decrees, executive orders, rules and
9 regulations, or parts thereof inconsistent with the provisions of this Act are hereby repealed or
10 modified accordingly.

11 **SECTION 17. Separability Clause.** — If, for any reason, any section of this Act shall be
12 deemed unconstitutional or invalid, the other sections or provisions shall not be affected and shall
13 remain in force and in effect.

14 **SECTION 18. Effectivity Clause.** — This Act shall take effect after fifteen (15) days from
15 its publication in the Official Gazette or in at least two (2) national newspapers of general
16 circulation, whichever comes earlier.

17 Approved.